

## CONFERENCE COMMITTEE REPORT DIGEST FOR EHB 1572

**Citations Affected:** IC 2-5-23-8; IC 12-13-5-14; IC 23-2-4.

**Synopsis:** Medicaid matters. Requires the health policy advisory committee to submit an annual report to the health finance commission on the committee's findings and recommendations. Revises the definition of "continuing care agreement". Specifies when a person providing continuing care has to register the continuing care retirement community with the securities commissioner. Eliminates payments to the Indiana retirement home guaranty fund after June 30, 2009. Requires that certain contractors for: (1) the division of family resources; (2) the office of Medicaid policy and planning; and (3) the office of the secretary of family and social services; that process eligibility intake information for the federal supplemental nutrition assistance program (SNAP), the temporary assistance to needy families (TANF) program, and the Medicaid program review certain intake statistics and provide certain information to the select joint commission on Medicaid oversight. Establishes the Medicaid managed care quality strategy committee to study issues related to Medicaid managed care. Requires the office of the secretary of family and social services to report certain information to the select joint commission on Medicaid oversight and requires the commission to determine whether legislation is needed on the issues. **(This conference committee report: (1) removes the provision requiring a study by the health finance commission of the quality assessment fee; (2) adds additional reporting responsibilities for contractors of the office of the secretary; (3) changes the appointing authorities for the Medicaid managed care quality strategy committee and adds additional duties for the committee; (4) removes the postponement until 2011 of the expiration of the quality assessment fee and other changes to the quality assessment fee; and (5) adds additional topics on which the office of the secretary of family and social services must report to the select joint commission on Medicaid oversight and that the commission must study during the 2009 interim.)**

**Effective:** Upon passage; January 1, 2009 (retroactive); July 1, 2009.

## CONFERENCE COMMITTEE REPORT

**MR. SPEAKER:**

*Your Conference Committee appointed to confer with a like committee from the Senate upon Engrossed Senate Amendments to Engrossed House Bill No. 1572 respectfully reports that said two committees have conferred and agreed as follows to wit:*

that the House recede from its dissent from all Senate amendments and that the House now concur in all Senate amendments to the bill and that the bill be further amended as follows:

- 1 Delete everything after the enacting clause and insert the following:
- 2 SECTION 1. IC 2-5-23-8 IS AMENDED TO READ AS FOLLOWS
- 3 [EFFECTIVE UPON PASSAGE]: Sec. 8. ~~Beginning May 1, 1997, (a)~~
- 4 The health policy advisory committee is established. At the request of
- 5 the chairman **of the commission**, the health policy advisory committee
- 6 shall provide information and otherwise assist the commission to
- 7 perform the duties of the commission under this chapter.
- 8 **(b)** The health policy advisory committee members are ex officio
- 9 and may not vote.
- 10 **(c)** The health policy advisory committee members shall be
- 11 appointed from the general public and must include one (1) individual
- 12 who represents each of the following:
- 13 (1) The interests of public hospitals.
- 14 (2) The interests of community mental health centers.
- 15 (3) The interests of community health centers.
- 16 (4) The interests of the long term care industry.
- 17 (5) The interests of health care professionals licensed under
- 18 IC 25, but not licensed under IC 25-22.5.
- 19 (6) The interests of rural hospitals. An individual appointed under
- 20 this subdivision must be licensed under IC 25-22.5.
- 21 (7) The interests of health maintenance organizations (as defined
- 22 in IC 27-13-1-19).

(8) The interests of for-profit health care facilities (as defined in IC 27-8-10-1).

(9) A statewide consumer organization.

(10) A statewide senior citizen organization.

(11) A statewide organization representing people with disabilities.

(12) Organized labor.

(13) The interests of businesses that purchase health insurance policies.

(14) The interests of businesses that provide employee welfare benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.

(15) A minority community.

(16) The uninsured. An individual appointed under this subdivision must be and must have been chronically uninsured.

(17) An individual who is not associated with any organization, business, or profession represented in this subsection other than as a consumer.

**(d) The chairman of the commission shall annually select a member of the health policy advisory committee to serve as chairperson.**

**(e) The health policy advisory committee shall meet at the call of the chairperson of the health policy advisory committee.**

**(f) The health policy advisory committee shall submit an annual report not later than September 15 of each year to the commission that summarizes the committee's actions and the committee's findings and recommendations on any topic assigned to the committee. The report must be in an electronic format under IC 5-14-6.**

SECTION 2. IC 12-13-5-14 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]: **Sec. 14. (a) As used in this section, "commission" refers to the select joint commission on Medicaid oversight (IC 2-5-26-3).**

**(b) A contractor for the division, office, or secretary that has responsibility for processing eligibility intake for the federal Supplemental Nutrition Assistance program (SNAP), the Temporary Assistance for Needy Families (TANF) program, and the Medicaid program shall do the following:**

**(1) Review the eligibility intake process for:**

**(A) document management issues, including:**

**(i) unattached documents;**

**(ii) number of documents received by facsimile;**

**(iii) number of documents received by mail;**

**(iv) number of documents incorrectly classified;**

**(v) number of documents that are not indexed or not correctly attached to cases;**

**(vi) number of complaints from clients regarding lost documents; and**

**(vii) number of complaints from clients resolved regarding lost documents;**

**(B) direct client assistance at county offices, including the:**

**(i) number of clients helped directly in completing**

eligibility application forms;  
(ii) wait times at local offices;  
(iii) amount of time an applicant is given as notice before a scheduled applicant appointment;  
(iv) amount of time an applicant waits for a scheduled appointment; and  
(v) timeliness of the tasks sent by the contractor to the state for further action, as specified through contracted performance standards; and

(C) call wait times and abandonment rates.

(2) Provide an update on employee training programs.

(3) Provide a copy of the monthly key performance indicator report.

(4) Provide information on error reports and contractor compliance with the contract.

(5) Provide oral and written reports to the commission concerning matters described in subdivision (1):

(A) in a manner and format to be agreed upon with the commission; and

(B) whenever the commission requests.

(6) Report on information concerning assistance provided by voluntary community assistance networks (V-CANs).

(7) Report on the independent performance audit conducted on the contract.

(c) Solely referring an individual to a computer or telephone does not constitute the direct client assistance referred to in subsection (b)(1)(B).

SECTION 3. IC 23-2-4-1, AS AMENDED BY P.L.27-2007, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 1. As used in this chapter, the term:

"Application fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in processing the individual's application to become a resident.

"Commissioner" means the securities commissioner as provided in IC 23-19-6-1(a).

"Continuing care agreement" means the following:

(1) For continuing care retirement communities registered before July 1, 2009, an agreement by a provider to furnish to at least one (1) an individual, for the payment of an entrance fee of at least twenty-five thousand dollars (\$25,000) and periodic charges:

(A) accommodations in a living unit of a home and continuing care retirement community;

(1) (B) meals and related services;

(2) (C) nursing care services;

(3) (D) medical services;

(4) (E) other health related services; or

(5) (F) any combination of these services;

for the life of the individual or for more than one (1) month, unless the agreement is canceled.

(2) For continuing care retirement communities registered after June 30, 2009, an agreement by a provider to furnish to an individual, for the payment of an entrance fee of at least twenty-five thousand dollars (\$25,000) and periodic charges:

(A) accommodations in a living unit of a continuing care retirement community;

(B) meals and related services;

(C) nursing care services;

(D) medical services;

(E) other health related services; or

(F) any combination of these services;

for the life of the individual, unless the agreement is terminated as specified under this chapter.

"Continuing care retirement community" includes both of the following:

(1) An independent living facility.

(2) A health facility licensed under IC 16-28.

"Contracting party" means a person or persons who enter into a continuing care agreement with a provider.

"Entrance fee" means the sum of money or other property paid or transferred, or promised to be paid or transferred, to a provider in consideration for one (1) or more individuals becoming a resident of a **home continuing care retirement community** under a continuing care agreement.

"Home" means a facility where the provider undertakes, pursuant to a continuing care agreement, to provide continuing care to five (5) or more residents.

"Living unit" means a room, apartment, cottage, or other area within a **home continuing care retirement community** set aside for the use of one (1) or more identified residents.

"Long term financing" means financing for a period in excess of one (1) year.

"Omission of a material fact" means the failure to state a material fact required to be stated in any disclosure statement or registration in order to make the disclosure statement or registration, in light of the circumstances under which they were made, not misleading.

"Person" means an individual, a corporation, a partnership, an association, a limited liability company, or other legal entity.

"Provider" means a person that agrees to provide ~~continuing care to an individual~~ under a continuing care agreement.

"Refurbishment fee" means the fee charged an individual, in addition to the entrance fee or any other fee, to cover the provider's reasonable costs in refurbishing a previously occupied living unit specifically designated for occupancy by that individual.

"Resident" means an individual who is entitled to receive benefits under a continuing care agreement.

"Solicit" means any action of a provider in seeking to have an individual residing in Indiana pay an application fee and enter into a continuing care agreement, including:

(1) personal, telephone, or mail communication or any other communication directed to and received by any individual in

Indiana; and

(2) advertising in any media distributed or communicated by any means to individuals residing in Indiana.

**"Termination" refers to the cancellation of a continuing care agreement under this chapter.**

SECTION 4. IC 23-2-4-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 2. This chapter applies to any person who:

(1) enters into a continuing care agreement in Indiana to provide care at a ~~home~~ **continuing care retirement community** located either inside Indiana or outside Indiana;

(2) enters into a continuing care agreement outside Indiana to provide care at a ~~home~~ **continuing care retirement community** located in Indiana;

(3) extends the term of an existing continuing care agreement in Indiana to provide care at a ~~home~~ **continuing care retirement community** located either inside Indiana or outside Indiana;

(4) extends the term of an existing continuing care agreement outside Indiana to provide care at a ~~home~~ **continuing care retirement community** located in Indiana; or

(5) solicits the execution of a continuing care agreement by persons in Indiana.

SECTION 5. IC 23-2-4-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 3. (a) A provider shall register each ~~home~~ **continuing care retirement community** with the commissioner if:

**(1) before opening the continuing care retirement community, the provider:**

**(A) enters into;**

**(B) extends; or**

**(C) solicits;**

**a continuing care agreement; or**

**(2) while operating the continuing care retirement community, the provider has entered into a continuing care agreement with at least twenty-five percent (25%) of the individuals living in the continuing care retirement community.**

**(b) If a provider fails to register a ~~home~~, continuing care retirement community, the provider may not:**

(1) enter into, or extend the term of, a continuing care agreement to provide continuing care to any person at that ~~home~~, **continuing care retirement community;**

(2) provide services at that ~~home~~ **continuing care retirement community** under a continuing care agreement; or

(3) solicit the execution, by persons residing within Indiana, of a continuing care agreement to provide continuing care at that ~~home~~, **continuing care retirement community.**

~~(b)~~ **(c) The provider's application for registration must be filed with the commissioner by the provider on forms prescribed by the commissioner, and must be accompanied by an application fee of two hundred fifty dollars (\$250). The application must contain the**

1 following information:

2 (1) an initial disclosure statement, as described in section 4 of this  
3 chapter; and

4 (2) any other information required by the commissioner under  
5 rules adopted under this chapter.

6 ~~(c)~~ (d) The commissioner may accept, in lieu of the information  
7 required by subsection ~~(b)~~; (c), any other registration, disclosure  
8 statement, or other document filed by the provider in Indiana, in any  
9 other state, or with the federal government if the commissioner  
10 determines that such document substantially complies with the  
11 requirements of this chapter.

12 ~~(d)~~ (e) Upon receipt of the application for registration, the  
13 commissioner shall mark the application filed. Within sixty (60) days  
14 of the filing of the application, the commissioner shall enter an order  
15 registering the provider or rejecting the registration. If no order of  
16 rejection is entered within that sixty (60) day period, the provider shall  
17 be considered registered unless the provider has consented in writing  
18 to an extension of time; if no order of rejection is entered within the  
19 time period as extended by consent, the provider shall be considered  
20 registered.

21 ~~(e)~~ (f) If the commissioner determines that the application for  
22 registration complies with all of the requirements of this chapter, the  
23 commissioner shall enter an order registering the provider. If the  
24 commissioner determines that such requirements have not been met,  
25 the commissioner shall notify the provider of the deficiencies and shall  
26 inform the provider that it has sixty (60) days to correct them. If the  
27 deficiencies are not corrected within sixty (60) days, the commissioner  
28 shall enter an order rejecting the registration. The order rejecting the  
29 registration shall include the findings of fact upon which the order is  
30 based. The provider may petition for reconsideration, and is entitled to  
31 a hearing upon that petition.

32 SECTION 6. IC 23-2-4-4 IS AMENDED TO READ AS FOLLOWS  
33 [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 4. The  
34 initial disclosure statement shall contain the following information:

- 35 (1) The name and business address of the provider.  
36 (2) If the provider is a partnership, corporation, limited liability  
37 company, or association, the names and duties of its officers,  
38 directors, trustees, partners, members, or managers.  
39 (3) The name and business address of any person having a five  
40 percent (5%) or greater ownership interest in the provider or  
41 manager of the ~~home~~: **continuing care retirement community**.  
42 (4) A description of the business experience of the provider and  
43 its officers, directors, trustees, partners, or managers.  
44 (5) A statement as to whether the provider or any of its officers,  
45 directors, trustees, partners, or managers, within ten (10) years  
46 prior to the date of the initial disclosure statement:  
47 (A) was convicted of a crime;  
48 (B) was a party to any civil action for fraud, embezzlement,  
49 fraudulent conversion, or misappropriation of property that  
50 resulted in a judgment against ~~him~~; **the provider or**  
51 **individual;**

- 1 (C) had a prior discharge in bankruptcy or was found insolvent  
 2 in any court action; or  
 3 (D) had any state or federal licenses or permits suspended or  
 4 revoked in connection with any health care or continuing care  
 5 activities, or related business activities.
- 6 (6) The identity of any other ~~home~~ **continuing care retirement**  
 7 **community** currently or previously operated by the provider or  
 8 manager of the ~~home~~; **continuing care retirement community**.
- 9 (7) The location and description of other properties, both existing  
 10 and proposed, of the provider in which the provider owns a  
 11 twenty-five percent (25%) ownership interest, and on which  
 12 ~~homes~~ **continuing care retirement communities** are or are  
 13 intended to be located.
- 14 (8) A statement as to whether the provider is, or is affiliated with,  
 15 a religious, charitable, or other nonprofit association, and the  
 16 extent to which the affiliate organization is responsible for the  
 17 financial and contractual obligations of the provider.
- 18 (9) A description of all services to be provided by the provider  
 19 under its continuing care agreements with contracting parties, and  
 20 a description of all fees for those services, including conditions  
 21 under which the fees may be adjusted.
- 22 (10) A description of the terms and conditions under which the  
 23 continuing care agreement can be cancelled, or fees refunded.
- 24 (11) Financial statements of the provider prepared in accordance  
 25 with generally accepted accounting principles applied on a  
 26 consistent basis and certified by an independent certified or  
 27 public accountant, including a balance sheet as of the end of the  
 28 provider's last fiscal year and income statements for the last three  
 29 (3) fiscal years, or such shorter period of time as the provider has  
 30 been in operation.
- 31 (12) If the operation of the ~~home~~ **continuing care retirement**  
 32 **community** has not begun, a statement of the anticipated source  
 33 and application of funds to be used in the purchase or  
 34 construction of the ~~home~~; **continuing care retirement**  
 35 **community**, and an estimate of the funds, if any, which are  
 36 anticipated to be necessary to pay for start-up losses.
- 37 (13) A copy of the forms of agreement for continuing care used by  
 38 the provider.
- 39 (14) Any other information that the commissioner may require by  
 40 rule or order.
- 41 SECTION 7. IC 23-2-4-5 IS AMENDED TO READ AS FOLLOWS  
 42 [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 5. (a) Each  
 43 year after the initial year in which a ~~home~~ **continuing care retirement**  
 44 **community** is registered under section 3 of this chapter, the provider  
 45 shall file with the commissioner within four (4) months after the end of  
 46 the provider's fiscal year, unless otherwise extended by the written  
 47 consent of the commissioner, an annual disclosure statement which  
 48 shall consist of the financial information set forth in section 4(11) of  
 49 this chapter.
- 50 (b) The annual disclosure statement required to be filed with the

commissioner under this section shall be accompanied by an annual filing fee of one hundred dollars (\$100).

SECTION 8. IC 23-2-4-6 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 6. (a) A provider shall amend its initial or annual disclosure statement filed with the commissioner under section 3 and section 5 of this chapter at any time if necessary to prevent the initial or annual disclosure statement from containing any material misstatement of fact or omission of a material fact.

(b) Upon the sale of a ~~home~~ **continuing care retirement community** to a new provider, the new provider shall amend the currently filed disclosure statement to reflect the fact of sale and any other fact that would be required to be disclosed under section 4 of this chapter if the new provider were filing an initial disclosure statement.

SECTION 9. IC 23-2-4-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: **Sec. 7.5. (a) This section does not apply to a continuing care retirement community registered before July 1, 2009.**

**(b) A continuing care agreement may be terminated for any of the following reasons:**

**(1) The provider has determined that the resident is inappropriate for living in the care setting.**

**(2) The resident is unable to fully pay the periodic charges because the resident inappropriately divested the assets and income the resident identified at the time of admission to meet the ordinary and customary living expenses for the resident.**

**(3) Providing assistance to the resident would jeopardize the financial solvency of the provider and the other residents being served by the provider.**

**(4) The resident has requested a termination of the agreement as allowed under the agreement.**

SECTION 10. IC 23-2-4-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]: Sec. 10. (a) Except as provided by section 11 of this chapter, the commissioner shall require, as a condition of registration, that:

(1) the provider establish an interest-bearing escrow account with a bank, trust company, or other escrow agent approved by the commissioner; and

(2) any entrance fees received by the provider prior to the date the resident is permitted to occupy the living unit in the ~~home~~ **continuing care retirement community** be placed in the escrow account, subject to release as provided by subsection (b).

(b) If the entrance fee gives the resident the right to occupy a living unit that has been previously occupied, the entrance fee and any income earned thereon shall be released to the provider when the living unit is first occupied by the new resident. If the entrance fee applies to a living unit that has not been previously occupied by any resident, the entrance fee and any income earned thereon shall be released to the provider when the commissioner is satisfied that:

(1) aggregate entrance fees received or receivable by the provider

pursuant to executed continuing care agreements, plus:

(A) anticipated proceeds of any first mortgage loan or other long term financing commitment; and

(B) funds from other sources in the actual possession of the provider;

are equal to at least fifty percent (50%) of the aggregate cost of constructing, purchasing, equipping, and furnishing the ~~home~~ **continuing care retirement community** and equal to at least fifty percent (50%) of the estimate of funds necessary to fund startup losses of the ~~home~~, **continuing care retirement community**, as reported under section 4(12) of this chapter; and (2) a commitment has been received by the provider for any permanent mortgage loan or other long term financing described in the statement of anticipated source and application of funds to be used in the purchase or construction of the ~~home~~ **continuing care retirement community** under section 4(12) of this chapter, and any conditions of the commitment prior to disbursement of funds thereunder, other than completion of the construction or closing of the purchase of the ~~home~~, **continuing care retirement community**, have been substantially satisfied.

(c) If the funds in an escrow account under this section and any interest earned thereon are not released within the time provided by this section or by rules adopted by the commissioner, then the funds shall be returned by the escrow agent to the persons who made the payment to the provider.

(d) An entrance fee held in escrow shall be returned by the escrow agent to the person who paid the fee in the following instances:

(1) At the election of the person who paid the fee, at any time before the fee is released to the provider under subsection (b).

(2) Upon receipt by the escrow agent of notice from the provider that the person is entitled to a refund of the entrance fee.

(e) This section does not require a provider to place a nonrefundable application fee charged to prospective residents in escrow.

(f) A provider is not required to place a refurbishment fee of a prospective resident in escrow if a continuing care agreement provides that the prospective resident:

(1) will occupy the living unit within sixty (60) days after the refurbishment fee is paid; and

(2) will receive a refund of any portion of the refurbishment fee not expended for refurbishment if the continuing care agreement is cancelled before occupancy.

SECTION 11. IC 23-2-4-12 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:  
Sec. 12. Any money or property received by a provider as an entrance fee to a ~~home~~ **continuing care retirement community** constructed or purchased after August 31, 1982, or any income earned thereon, may be used by the provider only for purposes directly related to the construction, maintenance, or operation of that particular ~~home~~, **continuing care retirement community**. A ~~home~~ **continuing care retirement community** in operation on September 1, 1982, may not

1 use the entrance fees or income earned thereon after August 31, 1982,  
 2 for the construction, operation, or maintenance of another ~~home~~  
 3 **continuing care retirement community** constructed or purchased  
 4 after August 31, 1982.

5 SECTION 12. IC 23-2-4-13, AS AMENDED BY P.L.2-2006,  
 6 SECTION 180, IS AMENDED TO READ AS FOLLOWS  
 7 [EFFECTIVE JULY 1, 2009]: Sec. 13. (a) There is established the  
 8 Indiana retirement home guaranty fund. The purpose of the fund is to  
 9 provide a mechanism for protecting the financial interests of residents  
 10 and contracting parties in the event of the bankruptcy of the provider.

11 (b) To create the fund, a guaranty association fund fee of one  
 12 hundred dollars (\$100) shall be levied on each contracting party who  
 13 enters into a continuing care agreement after August 31, 1982, **and**  
 14 **before July 1, 2009**. The fee shall be collected by the provider and  
 15 forwarded to the commissioner within thirty (30) days after occupancy  
 16 by the resident. Failure of the provider to collect and forward such fee  
 17 to the commissioner within that thirty (30) day period shall result in the  
 18 imposition by the commissioner of a twenty-five dollar (\$25) penalty  
 19 against the provider. In addition, interest payable by the provider shall  
 20 accrue on the unpaid fee at the rate of two percent (2%) a month.

21 (c) Any money received by the commissioner under subsection (b)  
 22 shall be forwarded to the treasurer of state. The fund, and any income  
 23 from it, shall be held in trust, deposited in a segregated account,  
 24 invested and reinvested by the treasurer of state in the same manner as  
 25 provided in IC 20-49-3-10 for investment of the common school fund.

26 (d) All reasonable expenses of collecting and administering the fund  
 27 shall be paid from the fund.

28 (e) Money in the fund at the end of the state's fiscal year shall  
 29 remain in the fund and shall not revert to the general fund.

30 SECTION 13. IC 23-2-4-16 IS AMENDED TO READ AS  
 31 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:  
 32 Sec. 16. (a) If a ~~home~~ **continuing care retirement community** is  
 33 bankrupt and the operation of the ~~home~~ **continuing care retirement**  
 34 **community** is terminated, the board of directors shall, subject to the  
 35 approval of the commissioner, distribute from the guaranty association  
 36 fund established in section 13 to the living residents of the ~~home~~  
 37 **continuing care retirement community** an aggregate amount not to  
 38 exceed one-half (1/2) of the amount in the fund at the time of  
 39 disbursement. The amount each living resident is entitled to receive  
 40 shall be prorated, based on the total amount paid on behalf of the  
 41 resident by the contracting party under the continuing care agreement.  
 42 In no event may the amount paid to an individual resident under this  
 43 section exceed the total amount paid on behalf of that resident under  
 44 the continuing care agreement, less the total value of services received  
 45 under the agreement.

46 (b) Any living resident of the ~~home~~ **continuing care retirement**  
 47 **community** shall be eligible to receive distributions under subsection  
 48 (a), regardless of whether any contribution to the guaranty association  
 49 fund has been made on behalf of the resident.

50 (c) A resident compensated under this section assigns ~~his~~ **the**

1 **resident's** rights under the continuing care agreement, to the extent of  
 2 compensation received under this section, to the board of directors on  
 3 behalf of the fund. The board of directors may require an assignment  
 4 of those rights by a resident to the board, on behalf of the fund, as a  
 5 condition precedent to the receipt of compensation under this section.  
 6 The board of directors, on behalf of the fund, is subrogated to these  
 7 rights against the assets of a bankrupt or dissolved provider. Any  
 8 monies or property collected by the board of directors under this  
 9 subsection shall be deposited in the fund.

10 (d) The subrogation rights of the board of directors, on behalf of the  
 11 fund, have the same priority against the assets of the bankrupt or  
 12 dissolved provider as those possessed by the resident under the  
 13 continuing care agreement.

14 SECTION 14. IC 23-2-4-21 IS AMENDED TO READ AS  
 15 FOLLOWS [EFFECTIVE JANUARY 1, 2009 (RETROACTIVE)]:  
 16 Sec. 21. If the commissioner has reason to believe that a ~~home~~  
 17 **continuing care retirement community** is insolvent, the  
 18 commissioner may petition the superior or circuit court of the county  
 19 in which the ~~home continuing care retirement community~~ is located,  
 20 or the superior or circuit court of Marion County, for the appointment  
 21 of a receiver to assume the management and possession of the ~~home~~  
 22 **continuing care retirement community** and its assets.

23 SECTION 15. [EFFECTIVE UPON PASSAGE] (a) **As used in this**  
 24 **SECTION, "committee" refers to the Medicaid managed care**  
 25 **quality strategy committee created by this SECTION.**

26 (b) **The Medicaid managed care quality strategy committee is**  
 27 **created to provide information on policy issues concerning**  
 28 **Medicaid. The committee shall study issues related to the**  
 29 **following:**

- 30 (1) **Emergency room utilization.**
- 31 (2) **Prior authorization.**
- 32 (3) **Standardization of procedures, forms, and service**  
 33 **descriptions.**
- 34 (4) **Effectiveness and quality of care.**
- 35 (5) **The number of denials by a managed care organization,**  
 36 **the reasons for the denials, and the number of appeals and**  
 37 **overturning of denials by a managed care organization.**
- 38 (6) **How reimbursement rates are determined by a managed**  
 39 **care organization, including reimbursement rates for**  
 40 **emergency room care and neonatal intensive care.**

41 (c) **The committee consists of seven (7) members as follows:**

- 42 (1) **Two (2) individuals representing Medicaid providers.**
- 43 (2) **One (1) individual representing public hospitals.**
- 44 (3) **Two (2) individuals representing Medicaid managed care**  
 45 **organizations.**
- 46 (4) **One (1) individual representing mental health professions.**
- 47 (5) **One (1) individual from the office of Medicaid policy and**  
 48 **planning, who shall act as chairperson of the committee.**

49 (d) **The president pro tempore of the senate shall appoint three**  
 50 **(3) members under subsection (c) as follows:**

- 51 (1) **One (1) member described in subsection (c)(1).**

1           **(2) One (1) member described in subsection (c)(3).**

2           **(3) One (1) member described in subsection (c)(5).**

3           **(e) The speaker of the house of representatives shall appoint**  
4 **three (3) members under subsection (c) as follows:**

5           **(1) One (1) member described in subsection (c)(1).**

6           **(2) One (1) member described in subsection (c)(2).**

7           **(3) One (1) member described in subsection (c)(3).**

8           **(f) The chairperson of the legislative council shall appoint one**  
9 **(1) member described in subsection (c)(4).**

10          **(g) The office of the secretary of family and social services shall**  
11 **staff the committee.**

12          **(h) The affirmative votes of a majority of the members are**  
13 **required for the committee to make recommendations.**

14          **(i) Before October 1, 2009, and October 1, 2010, the committee**  
15 **shall report to the select joint commission on Medicaid oversight**  
16 **established by IC 2-5-26-3 concerning the committee's**  
17 **recommendations.**

18          **(j) This SECTION expires December 31, 2010.**

19          SECTION 16. [EFFECTIVE UPON PASSAGE] **(a) As used in this**  
20 **SECTION, "commission" refers to the select joint commission on**  
21 **Medicaid oversight established by IC 2-5-26-3.**

22          **(b) Before October 1, 2009, the office of the secretary of family**  
23 **and social services shall provide the commission with information**  
24 **concerning the following:**

25           **(1) An update on the medical review team and whether the**  
26 **medical review team has a backlog of cases in need of review.**

27           **(2) Coordination of benefits.**

28           **(3) The extension of the office of the secretary of family and**  
29 **social services.**

30          **(c) During the 2009 interim, the commission shall study the**  
31 **issues and information provided in subsection (b) and determine**  
32 **whether any legislation action is necessary for the 2010 session.**

33          **(d) This SECTION expires December 31, 2009.**

34          SECTION 17. **An emergency is declared for this act.**

(Reference is to EHB 1572 as reprinted April 15, 2009.)

**Conference Committee Report**  
**on**  
**Engrossed House Bill 1572**

**S**igned by:

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Representative Welch  
Chairperson

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Senator Lawson C

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Representative Turner

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Senator Errington

**House Conferees**

**Senate Conferees**